

DOCUMENT RESUME

ED 164 907

CE 019 192

TITLE State Level Programs to Prepare and Use Mental Health Manpower in a State Mental Health Agency.

INSTITUTION Southern Regional Education Board, Atlanta, Ga.

SPONS AGENCY National Inst. of Mental Health (DHEW), Rockville, Md.

PUB DATE Jun 74

NOTE 46p.; For related documents see CE 019 195-197. Not available in hard copy because of broken type

EDRS PRICE MF-\$0.83 Plus Postage. HC Not Available from EDRS.

DESCRIPTORS *Adult Education; Career Ladders; Certification; Continuous Learning; Cost Effectiveness; Delivery Systems; Employment Qualifications; Institutional Role; Job Market; Job Training; *Manpower Development; Manpower Needs; *Manpower Utilization; *Mental Health Programs; Occupational Mobility; Personnel Selection; Prediction; Program Development; Program Planning; Recruitment; Staff Improvement; *State Agencies; State Aid

ABSTRACT

To assist mental health agency leaders and others concerned with state mental health manpower development, these guidelines (presented in ten sections) explore various issues and approaches and indications for using one approach over another. The first three sections focus on designing and conducting manpower studies, making long range projections of manpower needs, and determining elements of manpower utilization. Section 4 examines the trend toward developing career systems that allow workers who demonstrate competency to move from one level to another. The fifth section explores the problem of linking educational institutions to delivery systems so that programs train sufficient persons in needed competencies. Recruitment and selection of persons for specific jobs and for training in the mental health disciplines are discussed in section 6. Section 7 reviews the meaning of licensure and certification, and the following section outlines continuing education program objectives and provider responsibilities. Section 8 addresses the need for coordinated funding and cost effectiveness studies. The final section proposes guidelines for planning and implementing a manpower development program. (Documents on the following aspects of continuing education in mental health are also available: sanctioning and credentialism [CE 019 195], financing [CE 019 196], and needs, assessment, and evaluation [CE 019 197].)

(CSS)

* Reproductions supplied by EDRS are the best that can be made *

* from the original document. *

ED164907

STATE LEVEL PROGRAMS TO PREPARE AND USE MENTAL HEALTH MANPOWER

In a State Mental Health Agency

June, 1974

Under Grant From

THE NATIONAL INSTITUTE OF MENTAL HEALTH
Grant No. 11668

Sponsored by

THE SOUTHERN REGIONAL EDUCATION BOARD
130 Sixth Street, N.W.
Atlanta, Georgia

CE 019 192

U.S. DEPARTMENT OF HEALTH,
EDUCATION & WELFARE
NATIONAL INSTITUTE OF
EDUCATION

THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF EDUCATION POSITION OR POLICY.

CONTENTS

FOREWORD.....	111
INTRODUCTION.....	1
MEMBERS OF THE TASK FORCE ON MENTAL HEALTH MANPOWER DEVELOPMENT PROGRAMS.....	5
MANPOWER STUDIES.....	7
MANPOWER PROJECTIONS.....	13
MANPOWER UTILIZATION.....	17
CAREER SYSTEMS.....	21
RELATIONS TO EDUCATIONAL INSTITUTIONS.....	25
RECRUITMENT AND SELECTION.....	29
LICENSURE AND CERTIFICATION.....	33
CONTINUING EDUCATION.....	37
FINANCING AND COST EFFECTIVENESS.....	41
PLANNING AND IMPLEMENTING A MANPOWER DEVELOPMENT PROGRAM.....	43

FOREWORD

The Mental Health Program of the Southern Regional Education Board grew out of a resolution of the Southern Governors Conference in 1954. The major concern of the governors at that time was the shortage of manpower for the public mental health programs. The Mental Health Program at the Southern Regional Education Board was therefore charged to "stimulate and facilitate mental health training and research" in the 14 state region. Much of the program activity of the past 20 years has been focused on training per se. However, it is becoming apparent to state and national leaders that simply training more workers is not the answer to our manpower problems of distribution, utilization and retention.

For the past four years the Mental Health Program has had a Conference on Continuing Educational Opportunities made up of the staff development or training officers of the state mental health agencies of the region to facilitate the whole matter of staff development within the state mental health agency. This is supported by Grant Number T15 MH 11668 from the Continuing Education Branch of the National Institute of Mental Health.

In February, 1973 the Conference set up a task force to explore the many dimensions of total manpower development for the mental health services (public and private) and to make suggestions and recommendations for ways in which a state might better address its total mental health or human service manpower needs.

This publication is the result of that task force's deliberations. We hope it will be useful to mental health administrators, legislators, governmental leaders such as personnel and budget directors, educators and professional leaders.

We are particularly grateful to the members of the task force who worked on this project and to the members of the Conference who made their inputs and reviewed it. We are also grateful to Dr. Neil Waldrop, director of the Division of Manpower and Training and Mr. Warren Lamson, chief of the Continuing Education Branch of NIMH for their support and assistance.

Harold L. McPheeters, M.D.
Director, Commission on Mental
Illness and Retardation
Southern Regional Education Board

INTRODUCTION

In recent years the leaders of state mental health programs have become increasingly aware of the need to give specific attention to the many dimensions of manpower development. In most programs salaries for staff (manpower) make up 70% of the mental health program budget yet this is perhaps the most inelastic element of all of the resources. Most states commit a substantial portion of their budgets to training (from 5% to 17%) activities in a range of professional, technical and continuing education programs. There have been studies of mental health manpower by comprehensive mental health planning groups, but still manpower remains a critical problem.

Examples

Most mental health programs find themselves short of psychiatrists, yet many of the psychiatrists who might be employed are prepared for mainly one-to-one psychotherapy. They are not trained to work with a team of professionals and paraprofessionals to serve a large number of clients. Rural mental health programs and programs in poverty areas find it almost impossible to recruit the numbers of professionals they need. There are often struggles between the various disciplines regarding the roles and models each is to play in any collaborative team effort. Middle level workers trained in community colleges often find no jobs have been established although there are still claims of

manpower "shortages".

Over the years both the federal government and state governments and individual colleges and universities have supported and encouraged the training of more mental health professionals, especially of the big four - psychiatrists, clinical psychologists, psychiatric social workers and psychiatric nurses. Yet the shortages problems, the distribution problems, and the utilization problems remain.

The Complexity of Manpower Development

There is now a growing awareness that mental health manpower development must concern itself with many complex issues beyond just manpower studies and primary training of mental health workers. A thoughtful analysis reveals what a truly complex business mental health manpower really is. Among the many aspects that must be considered in addition to manpower studies and primary training of workers are manpower projections, manpower utilization, career systems, middle level mental health workers, recruitment, cost effectiveness, licensing and certification, financing and continuing education.

The Trend to Human Resources Agencies

The manpower situation in state government is presently becoming more complex as many states are moving to combined departments of human resources which bring together mental health, mental retardation, alcohol and drug abuse, physical health, family and children services, welfare, vocational rehabilitation and sometimes corrections into a single delivery and manpower system. The overall agency is often concerned with finding ways to use the existing manpower of all of these agencies in more flexible ways to better serve the clients. But whether the states are combining the service delivery system or not, they still

find that there is need for more systematic approaches to manpower development for all of the individual programs and that most of these agencies use many of the same kinds of workers. In fact many human service workers make their careers by moving from one state agency program to another as they gradually ascend a career spiral by making career advances with each successive move.

The Conference on Continuing Educational Opportunities of SREB

Very few state mental health or human service agencies have given comprehensive attention to this whole matter of manpower planning and development. The Conference on Continuing Educational Opportunities of the Southern Regional Education Board is made up of the directors of staff development or training from the mental health and mental retardation agencies of the South. While their concern is primarily for the many aspects of training (basic professional training, in-service training, orientation programs and continuing education), they are also concerned with the total picture of mental health manpower development, especially as it relates to the public mental health services of their states. They are aware of the recent intention of the federal government to change the existing pattern of financial support for basic education in the professional disciplines of psychiatry, clinical psychology, social work and psychiatric nursing to make future support of training responsive to the specific manpower needs of the mental health service agencies in the states rather than to the needs of the individual professions. This intention of the federal government makes it especially desirable for the states to develop their own mental health or human service systems in order to be responsive to new directions as well as to be more responsive to their own legislatures, merit systems, budget officials and boards of higher education which are also looking to the state

mental health agencies for guidance in their own programming.

Task Force on Manpower Development

The Conference on Continuing Educational Opportunities named a Task Force on Mental Health Manpower Development in the Spring of 1973 to pool the experience and judgment of the states in providing alternative guidelines regarding some of the many complex issues facing the states in mental health manpower development. This is the report from that Task Force.

These guidelines are in no sense directive. Rather they are exploratory of some of the various issues and alternative approaches together with the indications for using one approach over another. They are not exhaustive of all possible issues, but illustrative of some of the common issues and considerations. They are being set down in order to provide assistance to responsible mental health agency leaders, professionals, educators, personnel officials, staff development officers and other planners, citizens groups, budget officers, legislators and others who are concerned with mental health manpower development in the states.

MEMBERS OF THE TASK FORCE ON MENTAL HEALTH MANPOWER DEVELOPMENT PROGRAMS

Mr. Homer DeGlandon
Texas Department of Mental Health
and Mental Retardation
Austin

Ms. Joyce Stringer
Georgia Department of Human Resources
Atlanta

Dr. Hilton Levine
National Institute of Mental Health
Rockville

Dr. William Thomas
North Carolina Department of Mental
Health
Raleigh

Dr. Thomas Ray
Florida Division of Mental Health
Tallahassee

Dr. Louis Weinbaum
Virginia Department of Mental Health
and Mental Retardation
Richmond

Mr. Anthony Stout
Maryland Department of Mental
Hygiene
Baltimore

Consultant:

Ms. Pauline Gingras
Maine

MANPOWER STUDIES

Manpower studies are a logical starting point for manpower development programs, but they are only a starting point. There are several points to keep in mind regarding manpower studies:

1. In designing and conducting manpower studies, the staff will want to think of the studies and the data as a basis for action rather than primarily for scientific or historical reports. The approaches to data gathering, the questions to be asked, the sources to be queried, etc. are somewhat different when the ultimate objective is action.
2. Sampling studies or special studies may be more important than extensive surveys.
3. Judgments and perceptions of the future may be more significant than the facts of the present.
4. Ready availability of data may be more useful than scientific perfection. The manpower situation is a rapidly moving target so that time consuming precision becomes relatively meaningless.

Scope of Manpower Studies

Most mental health manpower studies have concerned themselves with a single profession (i.e., psychiatry, psychology or nursing) and often within just a single system such as the state mental hospitals. Many have suffered from trying to find answers to so many questions in a questionnaire that the responses comprised only a small sample of the known manpower. Often the data has been aggregated by state totals so that it is difficult to analyze distribution problems or other specific manpower patterns within the states. A very

basic question that must be answered at the start of a manpower study is the scope of the study itself.

1. We suggest that mental health manpower studies include data on all professions and technologies in a state using the same basic formats, schedules and techniques.
2. This would include data from state mental health agencies, mental retardation agencies, alcohol and drug abuse agencies, local community mental health programs, voluntary programs, private practice and private hospitals, university and college training programs and federal agencies (perhaps excepting the armed forces).
3. In some states such a study would most appropriately include all human service manpower, not just mental health manpower. In any case the study should at least recognize that many "mental health" professionals are employed in other kinds of agencies such as corrections, public schools and public welfare.
4. Ideally this data would be broken down by smaller sub-regions of the state so that it can show distribution for regional planning. A very helpful study of health, rehabilitative and social service manpower in Arkansas a few years ago displayed the data by small subregions made up of three or four counties surrounding a community such as Magnolia, Eldorado or Fayetteville.
5. Ideally such a study would include data about:
 - a. existing manpower (where trained, geographic origin, etc.)
 - b. reasonable demand for future manpower - including vacancies, standards to be met, (i.e., based on Alabama court order to Joint Commission on Accreditation of Hospitals), and anticipated program changes (drug, alcohol, etc.)
 - c. the state's training capacity for manpower
 - 1) basic training programs for professional manpower
 - 2) continuing education - for existing employees

If all of this data were related to small sub-regions of the state and covered all significant professions and technologies, and were done in such a way that the results were rather quickly available, there would be a very useful manpower planning base. For continuous planning these studies might be set up to be repeated rather easily a regular periods of time such as every other year.

This is a big job, of course. However, not all of this data must be gathered from original surveys.

Existing Manpower

For existing manpower most professions already have most of this data available in the records of licensing or registration boards or in the membership rosters of professional organizations. There is considerably more difficulty with some of the technologies and "irregulars." The "irregulars" are persons who do considerable mental health work but who often are not systematically viewed as mental health workers, such as chaplains and pastoral counselors, alcohol and drug counselors, sheltered employment personnel, volunteer program coordinators and mental health educators. In all of this, an early decision must be made about which professions and specialties are sufficiently problematic to include in the studies.

Sampling Studies for Planning Purposes

There would appear to be real virtue in doing a study of this kind in functional but not perfectionistic detail. The manpower situation is sure to have changed somewhat by the time a report of a study is issued. Thus there would appear to be little need for 100% surveys of all professional workers.

1. Sampling studies are more appropriate. What is most needed is sufficient data for administrators to use in making their policy decisions rather than data for reporting in a scientific journal.
2. For these purposes reasonably close estimates that are rather quickly obtained are likely to be more useful than precise data that may require several months of repeated questionnaires. This data may be more quickly obtained from a few key local leaders than from mail questionnaires sent to all practitioners or agencies.

Reasonable Demand

The matter of obtaining an estimate of reasonable demand require some

special attention. On the one hand there is a tendency to ask for data on "present vacant positions." This approach is likely to give numbers that are considerably under realistic demand since most agencies have a certain amount of administrative flexibility to convert some positions from one set of requirements to another depending on availability of workers. Also this approach is not likely to provide manpower data on programs that are in the planning stages but which will be implemented in the near future. At the opposite extreme is the tendency to ask "how many positions are needed?" which tempts respondents to give blue-sky estimates of "need" that are far too high to ever be filled within the limits of budgets and personnel practices.

1. The surveyor is faced with the problem of wording this question so that it reflects reasonable and realistic future demands as well as current vacancies. The surveyor will want to assure that projections of need also include staffing needs for programs that are planned for the near future but which are not yet in operation.
2. There is also the matter of how far into the future one should be asking for estimates. At the level of manpower studies of this kind there is little need for asking for data beyond five years in the future and probably two or three years will be more useful. There are too many changes in personnel, administrative and public policy, technology, etc., to make local estimates useful beyond five years. However, longer range projections are needed at a broader manpower policy level and will be considered in the section on Manpower Projections.

Training Resources

Surveys of manpower training resources pose some of the same issues as information about manpower demand. It is desirable to have information on:

1. current enrollments
2. current vacancies in training capacity
3. geographic distribution of training programs within the state
4. some notion of the geographic area of origin of students in those training programs that serve an entire state

5. In cases where major training resources lie close to a state line, it is well to include information about the extent to which the students are residents of the neighboring state or plan to practice there.

Manpower planners should be aware that much information about training programs is already available in other places such as boards of higher education and licensing and accrediting organizations. It is not necessary to do original surveys for all this information.

Special Studies

From time to time it will be desirable to do special studies to gain in-depth information about special aspects of manpower or training (i.e., continuing education resources, financing of students or programs, drop-outs, demographic data, turnover in agencies, salaries, etc.) but there appears to be little need to monitor every kind of data on a routine basis for overall manpower planning.

MANPOWER PROJECTIONS

The art of making long range projections of manpower needs is still very crude. There are several useful approaches to making manpower projections and a few others that have somewhat limited usefulness.

Basic Population Data

There are certain kinds of data that are very basic for making manpower projections. There are 1) the basic population and 2) area economic growth projections from the Bureau of the Census and from local and regional planning bodies. Most of the people for whom we shall be planning mental health services over the next ten years have already been born. The population projections can tell us much about their demographic characteristics and their overall living circumstances for the next ten years. These data are fairly firm in telling which geographic areas are likely to increase or diminish in population and the socioeconomic trends that are expected. From these we can estimate something of the client needs for services.

Predicting Public Policy, Economics, etc.

The remainder of the system is much less certain and depends on plans and predictions of future patterns of services more than just predictions for manpower. This involves all of the complex factors of economics, public demand, organization of services, public policy and technology. In mental

health this involves estimating whether National Health Insurance will pass, whether it will include coverage for mental disability, what it will cover more than just the physician's services, whether community mental health centers will continue to grow, whether the state mental hospitals will continue to diminish and/or be phased out, whether new community alternatives to institutional care will be developed, whether new kinds of manpower will be widely accepted and used, whether new psychopharmacologic agents will reduce the need for manpower, whether new state level organizations of human resources will change the kinds of mental health manpower needed, whether schools, courts and other agencies will increase their use of mental health manpower, etc.

It also requires estimates regarding the state of the general economy, manpower trends in other fields, the trends in mental disorders (i.e., will drug abuse continue to be a major problem?). These future patterns are far from certain, but it is possible to make some predictions about many of them.

At this time there are a few trends that seem to be stable:

1. The trend in services is still strongly away from institutional care for mental disability. Many persons predict that this trend will accelerate in institutions for the retarded as it has for mental hospitals. However, reduced patient loads have generally not resulted in fewer staff persons, until the point at which entire institutions or major segments of them are actually closed.
2. Despite dips in the economy, the general trend is likely to be continued expansion. Even the temporary dips seem to have relatively little effect on manpower demands except for a few months. However, many economists predict that the expansion of the relative proportion of the Gross National Product that has gone to health in the past decade will soon stop.
3. National health insurance is predicted to be a reality within five years but the coverage of mental disability is not so certain. Most early plans did not include mental illness. It is likely that coverage of mental disorders will be considerably limited at first. It is also possible that the focus on payment for specific medical services will face a gradual erosion in favor of some system of payment for a "client-day" of services which will include all kinds of individual services.

4. In making predictions for specific states it is possible to identify certain factors more precisely. Does this state have a rapidly growing population and economy, or does it have more stable patterns? Is this a state that rapidly adopts new social and organizational forms or is it somewhat traditional and conservative? What are the political trends that could lead to drastic policy and program changes in mental health?
5. The same kinds of predictions may be applied to sub-regions of states, the major cities, rural areas, depressed areas, etc. The patterns of mental health manpower distribution are certainly not the same for all of these various areas today and there is little reason to think they will be the same in the future.

Predicting Patterns of Manpower Utilization

Another major consideration related to predicting future patterns of manpower utilization in the various parts of the state and the mental health system. Will professionals be used primarily as therapists or as consultants and teachers for other workers? Will middle level workers be used or will the system demand only full time professionals? There will be more about utilization in a later section.

Relating to Overall State Plans for Mental Health, Mental Retardation and Alcohol Services

Each state is supposed to have an overall mental health service plan and overall plans for alcoholism, drug abuse, mental retardation, the aged, etc. that spell out the services to be developed and delivered over the coming years. These state plans presumably have already considered the above factors in developing their recommendations. Certainly mental health manpower projections should be related to the overall state mental health, mental retardation and addiction services plans. Perhaps there will have to be some modifications to reflect the manpower needs of any part of the state system that is not formally included in the state's service plans (i.e., the

universities or the Veteran's Administration), but the overall state mental health services plan will provide the logical base for a manpower development plan and for making manpower projections.

Limited Approaches to Manpower Predictions

There are two common approaches to making manpower projections that have limited use.

1. One of these is to apply some arbitrary "standard" of need devised by experts or professional associations. These standards are usually stated in such terms as "one physician is needed for every 600 people in the population." Often these standards are idealized figures. At other times these standards are based on the assumption that patterns for services, technologies, etc., will remain as they have been. In any case they are likely to be of limited usefulness because of their rigidity in the face of unique local differences.
2. Another common technique is to make straight line projections of past manpower trends into the future (i.e., "Since the number of psychiatrists in the state doubled in the past decade, we predict that it will again double in the next ten years.") This technique of projecting manpower needs has obvious flaws since it is based on the assumption that there will be no changes in public policy, technology, economics or utilization.

In fact the arbitrary application of any kind of formula across a state or program seems destined to be wrong except in the very crudest way. There are too many differences in the ways programs and services develop in the various states and especially in sub-regions such as rural areas, metropolitan areas, poverty areas, ghetto areas and affluent suburbs to be able to apply arbitrary formulas.

MANPOWER UTILIZATION

Most of what has been discussed so far relates to numbers of mental health professionals and workers. However, there is another dimension - that of how the workers are used that also has important implications for manpower development. Manpower utilization means different things to different people. It has at least these elements:

1. What do the professionals do in their professional work time? Do they do long term psychotherapy or short term treatment? Do they do individual therapy or group therapy? Do they do extensive and routine evaluations or more sharply targeted studies? Many observers believe that professionals could often use their time more effectively than they presently do.
2. Are the mechanics of working hours and conditions efficient so that maximum professional time is available for clinical work? Do professionals spend long hours waiting for patients to eat or be dressed and brought to treatment areas? Do staff spend time writing records that could be dictated? Can working hours be scheduled so that young women professionals might work part-time while their children are in school? Is too much time taken up by routine staff meetings, travel, etc? (Many hospitals have discontinued holding routine diagnostic and treatment conferences. New patients are assigned to a single team for immediate diagnosis and treatment as they see fit. Of course, the team can seek consultation if it needs it. A limited number of staff conferences are retained for training purposes.)
3. What kinds of teams are used? Most mental health agencies claim to use "the team approach" but there are many variations on "the team" that have important implications for manpower utilization. Among them are:
 - a. the traditional physician directed team in which every move of each member of the team is quarterbacked by the psychiatrist or

physician. This is sometimes referred to as the medical model and is most common in hospitals. It usually limits what various staff persons may do to only those activities prescribed by the physician.

- b. the evaluation team in which the patient is given a routine set of evaluations, studies and tests by the various professionals who then come together to decide on a diagnosis and treatment plan in a diagnostic staff conference. Some people feel this leads to unnecessary tests and lost time before treatment begins. It is wasteful of staff time for treatment.
 - c. the democratic team in which each worker has an equal vote in what happens to the patient. This sometimes leads to improper diagnostic and treatment plans and is often ponderous and slow.
 - d. the non-directive team in which the client pretty much decides his own course and to whom he will relate. This is fine for a reasonably aggressive client, but a passive person is likely to be overlooked.
 - e. the one-worker coordinated team in which one worker takes primary responsibility for a certain small group of clients. This may be one of the professionals or a mental health technician or other person. This tends to fix responsibility and gives the client the assurance of one person to whom he can relate regarding the totality of his problem.
4. What is the organization of staff? Is the staff organized according to professions (i.e., departments of nursing, departments of social services) or according to functional units in which all staff report to the unit director regardless of that person's profession? What are the patterns of supervision? Is supervision a matter of monitoring to assure that performance is meeting certain predetermined standards or does it include consultation and education to improve the person's performance?
5. How are the patients and services organized in relation to the staff?
- a. In most mental hospitals the patients traditionally were organized according to levels of nursing care (i.e., incontinent patient wards, acute patient wards, disturbed wards). This form of organization grew out of the custodial needs of an earlier time, but it also tends to use personnel in a way that reinforces custody.
 - b. Other hospitals have organized their patients by disease problem (i.e., alcoholic units, epileptic wards). The staff is then organized for "treatment" of the specific condition. However, this orientation provides limited rehabilitation.

c. Other hospitals have organized their patients according to geographic units in which the staff is more closely related to the human service personnel of the patients' home area. This organization seems to reinforce rehabilitation and earlier release of patients. These are issues that need careful consideration as we plan our programs to make best use of our manpower in meeting objectives for patients.

6. Are middle level workers (paraprofessionals) used and if so how? In the past few years there has been the development of a range of programs to training middle levels of mental health workers ranging from the New Careerists with intensive in-service training to Mental Health Technicians and Mental Health Associates with Associate degrees or Baccalaureate degrees. These training programs are located in technical education centers, 2 year community colleges and 4 year colleges.

Several of the states have written job descriptions for these new workers and are employing them; others have not. But how will they be used? a) as aides or assistants to one or another of the existing professions? b) as mental health generalists, assigned to a small group of clients and their families to help them with whatever the clients need in their treatment and rehabilitation by extending the competencies of all of the professionals? c) Will they be used only in new services and programs such as community after-care or crisis centers, or will they be used in the traditional in-patient and out-patient treatment programs? d) Will they be assigned to only a single kind of task or activity such as behavior modification, psychological testing or psychotherapy?

Most training programs are preparing their workers for the generalist role in order to extend the competencies of the professionals, but it remains for each agency to decide whether it will use these workers in that model or in one of the alternatives.

However, it is essential that a planful decision be made and the position descriptions and tables of organization be prepared according to that decision. The training programs will then hopefully modify the learning experiences for students in accordance with the decision about which role models the workers are to play.

Need for Thoughtful Consideration of Manpower Utilization

For the most part the leaders of mental health programs have given little attention to issues of how they organized and used their professionals and other workers. They have generally emulated a traditional pattern of organization of staff with little thought for overall efficiency of manpower

utilization. At times factors such as availability of certain kinds of workers or professional status or a pattern which could bring in the largest income have determined how manpower have been used. In the future we must be more critical about how we organize and use our manpower in order to achieve our mental health program objectives for clients and communities with maximum efficiency.

A statewide mental health manpower development program would not only examine existing manpower utilization patterns and make recommendations for change but would also set a plan and have staff assigned to bring about those changes. These changes might involve new procedures, new organizational structures, new manpower, new training programs, etc. It will require active work to bring these changes about, but that would be one of the responsibilities of a manpower development program.

CAREER SYSTEMS

The mental health manpower picture has been characterized by the lack of any real career systems for the workers except within a few professions. On the one hand were the professionals with full academic preparation - often at the masters or doctoral level. On the other hand were a large number of psychiatric aides and attendants who had only brief in-service education and no status in the system. They were generally presumed to carry out mainly custodial functions. There were virtually no career systems by which one of these persons could advance to professional status in the system without leaving work, going to college and a professional school and reentering in a professional job position. There have been a few rudimentary career opportunities, but they have tended to rely on seniority or advanced degrees within a single profession.

At present most of our society is moving to the concept of a manpower system that provides several levels of workers and career opportunities for workers to move from one level to another upon demonstration of additional competence regardless of whether this competence is obtained through accredited academic training or from experience on the job. The field of mental health and the human services is now also moving in this direction. The four general levels of workers are:

Level 1 - entry level or New Careers level. These are persons with no specialized job training before employment but an intensive period of in-service or technical school training. They carry out some of the most common functions of their field.

Level 2 - the technical level. These persons, with one or two years of specialized training for work in a technical school or community college and often with an associate of arts degree, carry out the ordinary day-to-day functions of the field.

Level 3 - the associate professional level. These persons, with approximately a baccalaureate degree of specific professional preparation in the field, carry out both ordinary and some extraordinary functions of the field plus some administrative duties. (This does not include persons with a general studies degree with no specific professional training.)

Level 4 - the professional or specialist level. Persons with full licensure or certification and often a masters or doctor's degree carry out all functions of the field plus teaching, research and administration.

While these levels are usually described in terms of the educational equivalents, they should not be tied to educational degrees, but rather to levels of competence. For each of these levels of workers it is desirable to develop standards of performance, a step which is only now beginning to be implemented.

Training and Use of New Levels of Mental Health Workers

New Careers programs to train Mental Health Assistants are a new but growing phenomenon. In addition over 170 colleges and schools presently offer two-year Associate of Arts degrees in mental health to train Mental Health Technicians or Associates. There are presently only a handful of baccalaureate programs in mental health, but there are several hundred baccalaureate programs in social welfare.

With the development of these training programs in the higher education system, some states have designed a career series of job specifications in mental health (i.e., Mental Health Worker Series) or in specific professions (nursing series, social work series, etc.). At present these career series

are largely on paper and have not become truly functional. However, the paper work is a necessary first step. There is still much to be done in defining the competencies and the criteria for movement of workers from one level to another (rather than just on the basis of seniority or academic credentials). There are also needs to decide upon patterns of utilization for the various levels and worker relationships to professionals. All of this also implies that the state should have a really effective employee evaluation program based on these decisions.

Salary Classifications

Important also is the salary classification given to the various levels of workers. There has been a tendency to pay aides and attendants very low wages, sometimes below the minimum wage, because of the great cost of the large numbers of these workers in the total mental health system. Pay levels should compensate the workers for increased competence and responsibilities and make it worthwhile for workers to want to advance their careers through the system both in terms of professional performance and in salary. In addition to a salary incentive for advanced supervisory performance, there will ideally also be provision for a worker to advance to high levels of salary classification based on professional performance alone. At present the only route to advancement is often by going into administration and leaving direct clinical work.

Career Patterns in the Human Services

One factor to be kept in mind in developing career systems in mental health is that there should be provision for articulations with other parts

of the mental health system (voluntary, local and private sectors) as well as with other human service agencies (welfare, corrections, rehabilitation, health, etc.). Most professionals have traditionally made their careers by moving from one agency to another of these systems. This leads to more rapid career ascendancy for the individual as well as providing a more widely experienced worker. Relatively few dynamic careers have been built by staying in a single agency and waiting for promotions there. This kind of career spiral through several agencies rather than just a rigid ladder concept within one's own agency should probably be encouraged for all levels of mental health careers. Those states and local governments that are moving to a combined human resources organization may find it relatively easier to provide for this kind of comprehensive career system than those states that maintain separate agencies for each of the human service programs.

Leadership for Career Systems

The whole process of establishing such a career series of job specifications and making them operational depends on the collaboration of many people including mental health agency leaders, personnel officers, merit system administrators and budget officers. It requires a good deal of time and effort and calls for reasonably aggressive leadership from the mental health program leaders since they are the persons basically responsible for instituting such changes in their own systems. There will also be ties to local technical education programs, community colleges and universities whereby workers can study to increase their knowledge and skills. A great deal of increased competence can come from job experience and staff development programs in the agencies, but it is also well to have ties to the higher educational system for career development programs.

TIES TO EDUCATIONAL INSTITUTIONS

A serious problem exists in linking the educational institutions to the delivery systems so that the training programs are training appropriate numbers of persons in the appropriate competencies and role models that are needed by the delivery system. In the past there have been poor connections between the two so that many observers have felt that the training programs have too often been preparing practitioners for a traditional one-to-one therapy model that leads them into private practice or case work jobs which may not be very helpful in terms of the broader service needs of the public delivery system.

Planning New Training Programs

At the level of program planning for new training programs there should be some consultation between the educational planners and the major agency systems to ascertain that the agency systems do indeed need workers of the kind that the colleges plan to train and to assure that jobs will be available at the time graduates are produced. This will also provide occasion to learn just what competencies are needed by the graduates:

1. In some state systems of higher education there is a person or a unit in the coordinating board of higher education that insists that this kind of planning be done before approval and funds will be granted for a new training program. This applies only to the state system of higher education, of course, and not to private colleges or universities.

2. The private colleges and universities must be approached individually. Sometimes there is a council or consortium of private colleges that can be involved.
3. The state coordinator of junior or community colleges is often separate from the rest of the system of higher education; often he is located within the state Department of Education.

With or without a state manpower program the college training programs should take the initiative to establish planning committees of faculty persons and selected representatives from local and state mental health agencies to ascertain their needs for workers and the specific competencies required as well as to plan for those parts of the training that will provide practicum or field learning for the students in the agencies. These committees ideally will remain active, meeting about four times a year even after the training programs have been planned and implemented to provide feedback for program evaluation and modification and for planning continuing education programs.

The Mental Health Agency Relation to Colleges

The major problems of linkages seem to lie with the mental health agency systems, however, for most of them have no overall manpower development program that can respond to requests from higher education even when they are made. If there were some kind of Mental Health or Human Services Manpower Development Commission or Office, this need could be better met. It would be most appropriate for the initiative for manpower planning to come from the agencies which are the ultimate users of the persons trained in the colleges. At the very least there should be one person from the state Mental Health agency (i.e., the staff development officer) who has responsibility for liaison with the higher education systems of the state.

Financial Support for Faculty and Students

In some cases the agencies may provide financial support for clinical faculty persons for the college programs, especially if these persons also have clinical responsibilities in the agency programs. This is a good way to provide the college with current information about the programs and training needs of agencies.

In other places the agencies will provide financial support for students in the training programs, either as stipends or as work-study programs. In these cases the agencies have a special responsibility to assure that the training is fairly specifically targeted to the practice needs of the agency, especially if this work-study mechanism is a part of the agency's career system to provide advancement opportunities for staff.

The Nature of Gaps Between Colleges and Agencies

There are certain gaps between the language and the orientation of college training programs and agency service programs that require special attention.

Perhaps the greatest problems in the gaps between what training institutions teach and what agencies expect of the workers lie in the area of role models and value systems rather than in basic knowledge and skills. The training institutions are likely to be inclined to prefer the one-to-one clinical treatment model and to ascribe lower status to other roles and functions such as consultation, team approaches, administration, rehabilitation, prevention and community mental health. They tend to "teach about" these other roles and functions while truly developing competence in the one-to-one clinical treatment models. If these differences are frankly

explored between both parties, it should be possible to develop training programs that provide competence in all of the functions and roles and that deal more realistically with the value issues. The agencies might provide the experiential learning opportunities for learning the alternative role models that are more appropriate for the public services.

Another of the gaps lies in the fact that the colleges and professional schools tend to teach basic clinical knowledge and basic clinical skills, but not the many complicated issues regarding the delivery of services in organized systems. Thus the graduates find themselves at a loss to know how to function with other kinds of workers in a public delivery system that has its basic value orientation in serving large numbers of persons with an adequate level of service rather than serving a limited number of clients at a somewhat idealized level of personal service.

Another problem lies in some of the language differences between academia and agencies. Academic persons tend to use a language of abstractions and generalizations while agency people use more practical and pragmatic language. Even the same words such as "evaluation" or "accountability" are likely to have different meanings in academia and in agencies. Both sides must be aware of this gap and ask for clear definitions to assure that they are talking about the same things.

RECRUITMENT AND SELECTION

There are at least two aspects of recruitment and selection that are important in mental health manpower development: 1) recruitment and selection of persons for training in the mental health disciplines and 2) recruitment and selection of persons for specific jobs. The first is of major concern to the training institutions and the latter to the mental health agencies.

Recruitment of Young People to Human Service Fields

Most states have had no systematic efforts to recruit young people into the mental health disciplines. The few programs that generally exist such as Future Nurse Clubs are more likely to be related to the biomedical aspects of Health rather than the mental health aspects of the health professions. However, there are a few examples of projects (such as Teens Who Care by the Kentucky Mental Health Manpower Commission) that combine volunteer or summer work with career information and counseling that have been found successful for stimulating mental health career interest in selected youngsters with a human service orientation. These programs work with high school counselors to make them aware of career opportunities in mental health as well as with the young people themselves. Programs of this kind may provide a key to the problems of geographic distribution of mental health manpower. If we recruit and select young people from the geographic areas in need, these

workers are more likely to return. A program of this kind requires a staff to manage the work.

Selection

For the academic institutions the problems tend to be more those of selection rather than recruitment. The colleges and universities tend to place the highest premium on academic aptitude and achievement in making their selections. Actually this may be putting undue emphasis on candidates whose main inclination is to teaching or research rather than to service. Some observers feel that more emphasis should be given to such factors as race, geographic origin, and long range career plans - so long as academic credentials are adequate. These factors might help solve some of the overall manpower problems of serving rural areas, poor neighborhoods, minorities, etc. Efforts of this kind have been successful in demonstration projects.

Recruitment to Jobs

When it comes to recruitment of trained workers into agency jobs, the issues are a bit different. It helps if the state has a coordinated recruitment program with all major agencies and institutions participating. In this way announcements and advertisements can be of high quality and more widely distributed. A single recruiting point can stress the varied advantages of the state such as climate, recreational opportunities and social opportunities as well as directing inquiries to the most appropriate agencies or institutions within the state.

In some states the state Merit System claims to do this kind of recruiting. However, for professional mental health workers the state Merit System's approach is seldom as effective as one developed by the mental health agency

itself (although this effort should be worked out together with the personnel people). The state mental health agency is usually able to give sharper attention to some of the finer distinctions in the recruitment of personnel with special qualifications. For instance they can be more selective in the recruitment of psychiatrists with an orientation to public service and they can discriminate between a baccalaureate social welfare graduate with specific skill training in human service work from a person with a general studies course.

LICENSURE AND CERTIFICATION

In some professions and states there are legal obstacles in various licensure and certification laws that restrict certain persons from performing functions which they might otherwise be able to perform on behalf of clients. These include provisions that middle level workers can work only under the supervision of full professional workers or provisions that certain middle level workers are restricted to only certain tasks. These restrictions may be found in psychology practice acts, nurse registration laws, medical practice acts and others. Occasionally such restrictions are established by administrative policy rather than by law.

In either case it is well to remember that laws and regulations are written by people and can be changed by people. This is sometimes hard to do - especially if it involves changing a practice act for an entire profession, most of which is not primarily related to the mental health field. Proposed changes are best negotiated ahead of time with key leaders in the appropriate professions and with members of the regulatory board that administers the laws. Spade work will also have to be done with key legislators and the governor's staff to inform them of the reasons for the changes and to assure that they understand the implications and support the changes.

Licensure

Licensure is a legal process for assuring that persons who hold themselves out to practice certain skills or professions either have passed an examination of competence or have graduated from an approved training program in the profession. This provides assurance of a basic level of competence. A license tends to become a right which is very difficult to revoke unless the worker becomes grossly incompetent. Since licensure provides a floor for basic competence only, it may be well to combine licensure with certification.

Licensure laws require very careful drafting to assure that they adequately protect the public and yet provide for a realistic delivery of service. It is all too easy to inadvertently put in a phrase or clause that will limit the adequate delivery of service in the public services by, for example, requiring a supervising professional to be on site or to have directed a middle level worker in whatever he does. Either restriction might make it impossible to provide any service at all in a remote rural area or in a poverty area.

Certification

Certification is a procedure for giving special recognition and rewards for training or qualification by examination - often beyond the basic requirements for licensure. Certification tells the public that the practitioner is qualified to call himself the specialist in the field in which he is certified. This may be rewarded by higher fee schedules or higher salary levels. However, certification does not prohibit a person from practicing, but only from using that title. It is basically a system for upgrading and

rewarding such improvement and as such should be used more than it is. Many specialty societies are now requiring recertification based on repeated tests of competence or on evidence of successful participation in continuing education programs.

CONTINUING EDUCATION

Another major aspect of mental health manpower development is that of continuing education. The needs for continuing education relate to three objectives:

1. to sharpen and deepen basic knowledge and skills.
2. to learn new knowledge and skills
3. to move programs into new directions. This is more related to use of continuing education as a management tool, but it has important clinical implications also.

Whose Responsibility?

The responsibility for organizing and planning continuing education programs is a mixed responsibility of 1) the colleges, 2) the professional associations and 3) the employing agencies with the result that none has done a very satisfactory job. Continuing education tends to be a second priority for each of these groups. However, there is an increasing movement for all of these parties to establish more formal mechanisms for dealing with continuing education:

1. In colleges this is represented by Division of Continuing Education or Extension Services.
2. In professions it is shown by continuing education task forces, and by requirements that members participate in continuing education as a condition for continued membership or certification.
3. In agencies it is manifested by officer of Staff Development or Training that have continuing education as a major concern along

with in-service education, basic professional education and orientation programs.

Making Continuing Education Relevant to Practitioners

A serious problem lies in making continuing education programs relevant to the needs of practitioners and in providing rewards and sanctions that motivate and make it possible for such persons to attend. Sometimes the university faculty make excellent teachers for continuing education, but they are often suspect by practitioners who are reluctant to put themselves back into a student role to be lectured to in subjects that appear more academic than practical. The focus must be on helping practitioners solve their immediate practice problems and to be more effective and efficient rather than just on learning academic concepts and principles. When theories are taught, they should be followed with practical applications.

1. Any devices that helps practitioners assess their own performance problems such as the Problem Oriented Record or self-assessment programs are likely to provide more accurate data about needs and to motivate persons to participate in continuing education.
2. In addition the agencies must provide sanctions and rewards (time off, travel, salary increases, etc.) for staff to make it possible and desirable for workers to participate in these programs.

Continuing Education for Community Practitioners

There is also the matter of providing continuing education in mental health for a range of community level practitioners such as family physicians, public health nurses, social workers, teachers, and clergymen to help them more effectively manage the emotional problems of clients they encounter in the course of their regular work. What are these needs? Will the state mental health program help meet them? How? A great deal remains to be done,

CS

but the entire effort will be speeded by specific committees of a Mental Health Manpower Commission assigned to work on continuing education within a state.

Funding of Continuing Education

There has been a tendency to put the responsibility for funding of continuing education on the individual practitioner in enrollment fees. This may be a short sighted policy unless there is also a strong requirement for continuing education to retain one's certification. Even then there are costs involved in assessing needs, planning and arranging sessions, etc. that exceed the usual instructional costs. These costs will have to be met by universities or agencies. An overall manpower development program can decide which.

FINANCING AND COST EFFECTIVENESS

Financing

The financing of mental health manpower development programs is presently splintered in most states with parts being funded to universities or community colleges and parts being funded to the state mental health agencies. This is true of both state and federal funds. Some of the costs for training are borne by private colleges, professional associations and the learners themselves.

Need for more Coordination of Funding

To a considerable extent this split responsibility will remain the pattern of financing in the future, but there is need for more coordination of the financing - especially that which comes from public tax sources. Many manpower development activities related to projections, utilization, etc., are simply not done in most states since there has been no funding or mechanism to do them.

1. Probably the most logical source for funding of an overall state mental health manpower development program would be the state. The exact mechanism will vary from state to state, but the funding will need to be assured from some strong source. Ideally the funding will be in a sufficient amount to support basic staff functions over some continuing period. This is more than just a two year "planning activity," but rather should expect to work for implementation of recommendations, periodic reassessment and on-going evaluation of the total mental health manpower development program of the state.

2. To this basic support there might be added amounts in specific contracts or grants from the federal government, the state government, private foundations, etc. These additional amounts would probably be for special studies or discrete projects that would have been developed from the basic program.

Cost Effectiveness

In recent years there has been a growing interest in cost effectiveness of human service programs. This should also be considered in a manpower development program. Unfortunately, the technology for doing cost effectiveness studies is still very rudimentary.

It appears, however, that it should be possible to identify major cost items related to such a manpower development program (i.e., whether more intensive in-service training programs result in higher quality care or whether a new pattern of utilization of staff results in serving more clients).

Any measures of cost effectiveness of manpower programs related to client outcomes will be determined by the program measures or outcome that are established for the overall mental health program. These measures will vary from state to state. We can probably look to the various payment programs (i.e., insurance programs and other third-party payment plans) to help develop these measures of outcome and cost effectiveness of manpower programs as well as of the total resources and organization of services. Much remains to be done in this area.

PLANNING AND IMPLEMENTING A MANPOWER DEVELOPMENT PROGRAM

In most states there has been no overall concern for mental health manpower planning and so there is no mechanism for either planning or implementing such a program. A few states have established Offices of Manpower or Staff Development within the state mental health agency. For the most part these offices have been concerned primarily with training for the manpower in and for that agency. There is seldom concern for the total picture of mental health of human service manpower development within the entire state.

An Example: The Kentucky Mental Health Manpower Commission

In Kentucky there is the Kentucky Mental Health Manpower Commission which was originally created by the Department of Mental Health, but which has always operated as a separate body to do studies, make recommendations and to carry out special projects in recruitment and new manpower use. While it has not concerned itself with the full range of mental health manpower development in the state, it has covered a wide range of problems and it provides a mechanism through which comprehensive manpower planning could be done.

The members of the Kentucky Mental Health Manpower Commission are persons such as chairman of departments of psychiatry and psychology, deans of social work and nursing, the state commissioners of mental health and

personnel, representatives from the departments of education and from private industry. There is a full time staff that is funded through contracts and grants from state agencies and the federal government. Such a mechanism as the Kentucky Mental Health Manpower Commission, which has been in existence since 1961, should be expected to continue in existence on an on-going basis to continuously do new studies, up date plans and continue efforts to implement recommendations.

Other Possibilities

In a few states, there have been Social Welfare Manpower Commissions with much the same kind of mission related to the fields of social work and social welfare. They might be expanded to include responsibility for mental health manpower development. Comprehensive Health Planning also has responsibility for manpower planning. In most states this has consisted mainly of general health manpower studies with little attention to mental health or to overall human services manpower development. However, Comprehensive Health Planning provides one possible mechanism for mental health manpower development. In a similar way Regional Medical Programs have had a special concern for continuing education in heart disease, cancer, stroke and kidney diseases. In some states this has included concern for continuing education in the emotional aspects of these conditions. This might provide a possible mechanism in some places. Texas has recently had manpower studies and planning by the Employment Commission which is another possible arrangement.

Placement Within the Mental Health Agency

In some states it may be best to lodge such a function within the state mental health agency or in an overall human resource agency if one exists. This arrangement will be ideal for up-grading the staff of the mental health agency. However, such a structure will have to work hard to overcome the suspicion among voluntary, private and local agencies that it is concerned only with manpower for the state services. This can be overcome by assuring that there are both representatives and data inputs from the other sectors.

Need for an On-Going Manpower Development Program

Such a mental health manpower development structure needs to be relatively permanent in order to do repeated studies and revise plans, but there is also the need for an expectation that the plans will be implemented. Thus the plans must be developed in close association with the persons who will be responsible for implementing them, and there must be sufficient staff to work on implementation as well as on planning. Every effort should be made to avoid making "blue-sky" plans that some agency or college "ought" to carry out if in fact the plans are not practical or agreeable to the persons who will have to carry them out. Thus there must be funds for travel, meetings, consultants, etc., to assure this kind of realistic planning and implementation. It also implies that the plans will spell out with some detail just how the plan will be implemented, by whom, by what time deadlines, and at what cost.

The Mental Health Manpower Commission, or whatever the structure will be, should then be charged with monitoring and facilitating the implementation of the plans and revising them as needed.

Initiating the Program

Perhaps the most visible way to start such a Mental Health Manpower Program is to have the governor appoint the initial members and issue an executive order spelling out the objectives, and how the program is expected to operate. The members would be named from a range of professional associations, education institutions, public and private mental health agencies, the state personnel system and perhaps others from the budget, the legislature and other state agencies.

Staff may initially be only one assigned specialist, but this should be watched closely since the need for more staff is likely to soon become apparent - especially if the program is to be truly effective.